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Supreme Court of the United States
OCTOBER TERM, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,
v.
DOROTHY SCOTT SULLIVAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF *AMICI CURIAE* AMERICAN INSURANCE ASSOCIATION, ALLIANCE OF AMERICAN INSURERS, NATIONAL ASSOCIATION OF INDEPENDENT INSURERS, INSURANCE FEDERATION OF PENNSYLVANIA, CALIFORNIA WORKERS' COMPENSATION INSTITUTE, STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, NATIONAL ASSOCIATION OF MANUFACTURERS, NATIONAL COUNCIL OF SELF-INSURERS, UWC-STRATEGIC SERVICES ON UNEMPLOYMENT & WORKERS' COMPENSATION, MICHIGAN SELF-INSURERS' ASSOCIATION, PENNSYLVANIA MANUFACTURERS ASSOCIATION, PENNSYLVANIA CHAMBER OF BUSINESS AND INDUSTRY, PENNSYLVANIA SELF-INSURERS' ASSOCIATION, PENNSYLVANIA DEFENSE INSTITUTE AND PENNSYLVANIA RETAILERS' ASSOCIATION IN SUPPORT OF PETITIONERS

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INTEREST OF THE *AMICI*

Amici curiae respectfully submit this brief in support of the petitioners.[1] *Amici curiae* American Insurance Association, Alliance of American Insurers and National Association of Independent Insurers are insurance industry trade associations whose member companies write a substantial portion of the workers' compensation insurance written nationally, including in Pennsylvania, the state in which this case arose. *Amicus curiae* State Farm Mutual Automobile Insurance Company writes automobile and homeowners' insurance in Pennsylvania and throughout the country. *Amici curiae* National Association of Manufacturers, National Council of Self-Insurers, UWC-Strategic Services on Unemployment & Workers' Compensation, Insurance Federation of Pennsylvania, California Workers' Compensation Institute, Michigan Self-Insurers' Association, Pennsylvania Manufacturers' Association, Pennsylvania Chamber of Business and Industry, Pennsylvania Self-Insurers' Association, Pennsylvania Defense Institute and Pennsylvania Retailers' Association are all trade, advocacy or research organizations that, among other things, represent the interests of employers, both those that purchase workers' compensation coverage from insurers and those that self-insure.

Amici have a substantial interest in the issues presented in this case for two reasons. *First*, the decision of the Third Circuit Court of Appeals subjects insurers and self-insured employers to liability for damages under 42 U.S.C. § 1983 when they handle claims disputes arising from their private contracts of workers' compensation insurance and self-insurance plans. *Second*, the Third Circuit's rul-

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[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no counsel for any party to this dispute authored this brief in whole or in part and no person or entity, other than *amici curiae* and their member companies, made a monetary contribution to the preparation or submission of this brief. Most of the insurance company petitioners are members of one of the *amici* insurance industry trade associations.

ing strikes down an important legislative reform of the workers' compensation system in Pennsylvania and threatens to undo similar reforms in other states designed to prevent medical care fraud and overutilization.

Based on *amici*'s familiarity with workers' compensation insurance and self-insurance, and with state regulation of both, this brief addresses the need for a state action standard clearly differentiating the regulated but discretionary private conduct of insurers and employers from the actions of the state itself.[2]

SUMMARY OF ARGUMENT

The standard workers' compensation insurance policy used in Pennsylvania (and elsewhere) obligates the insurer to pay only for medical treatment that is "reasonable and necessary." In 1993, in order to combat fraud and overtreatment by medical care providers, Pennsylvania enacted a law to permit insurers to seek "utilization review" of disputed treatment by independent physicians and other healthcare specialists and, pending such review, to withhold payment of bills submitted for the disputed treatment. The insurer has complete discretion whether to invoke this "self-help" remedy for enforcement of contractual limitations on coverage. There is no requirement that the insurer obtain advance state approval; its self-initiated decision to suspend payment is not subjected to any subsequent state review of a substantive nature; and its decision is not enforced by any state official.

The Third Circuit Court of Appeals nevertheless held that the insurers' privately-initiated decisions should be attributed to the state, for essentially three reasons: (1) Private insurers perform a public function because the payment of workers' compensation benefits is a "uniquely governmental obligation"; (2) insurers are in a "symbiotic relationship" with the state because they help administer a system of state "entitlements"; and (3) the state "actively encourages" the insurers' temporary withholding of payment for medical bills by authorizing it. *Sullivan v. Barnett*, 139 F.3d 158, 167-70 (3d Cir. 1998). Each of these rationales for converting the discretionary judgments of privately-owned insurers in claims disputes into state action should be rejected. They go far beyond the boundaries of this Court's "public function," "symbiotic relationship" and "active encouragement" tests for attributing the conduct of regulated businesses to the state:

"Government Function" Test: The "public function" test treats a private party as a state actor only when it performs activities traditionally undertaken *exclusively* by the state as sovereign. The payment of workers' compensation benefits historically has never been a state function at all, let alone an exclusive one. The payment obligation has always belonged to the employer, not the state. The enactment of workers' compensation laws earlier in this century did not shift any payment obligation from the state to the employer (or insurer); it merely changed the standard governing that obligation from negligence to no-fault.

"Symbiotic Relationship" Test: Nor does the insurer's status as a regulated business place it in a "symbiotic relationship" with the state or make it a "joint participant" in state action. "The mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment. . . . Nor does the fact that the regulation is extensive and detailed . . . do so." *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974) (footnote and citations omitted). A "symbiotic relationship" exists between a state government and a private business only where there is some financial interdependency, state assistance or mutual benefit, which is utterly lacking in the

[2] All parties have given blanket consent to the filing of all *amicus* briefs in this case, in letters of consent filed with the Office of the Clerk of this Court.

arms' length relationship between state officials and the workers' compensation insurers they regulate.

"Compulsion" or "Active Encouragement" Test: This Court has attributed the conduct of regulated private businesses to the state only where the state regulation so broadly eliminates the "private choice" or business discretion of the regulated company that the state law, in effect, compels, coerces, enforces or controls the private action. This limitation arises from the central purpose of the state action doctrine: "[T]o assure that constitutional standards are invoked only when it can be said that the State is *responsible* for the specific conduct of which the plaintiff complains." *Blum v. Yaretsky*, 457 U.S. 991, 1004 (1982) (emphasis in original).

Neither the Pennsylvania utilization review statute nor the actions of Pennsylvania workers' compensation regulators compelled, coerced, enforced or even actively encouraged insurer decisions to suspend payment of provider bills pending utilization review. The statute merely authorized insurers to invoke a "self help" remedy inherent in any private contractual relationship—a refusal to provide contractual benefits pending resolution of a dispute about the scope of the contractual obligation. Pennsylvania merely authorized the insurer to elect to work out an insurance coverage dispute by private means *without* the need for significant state involvement.

The state's only role in the claims dispute is to require the insurer to make a notice filing—after the decision to withhold payment already has been made—formally requesting referral of the dispute to utilization review, a request automatically granted if it meets procedural filing requirements. The state's mere acquiescence in the insurer's privately-initiated decision falls far short of the "coercion," "significant encouragement" or "active assistance" that is required for imputing a private party's decision to the state.

The Third Circuit's expansionist state action standards should also be rejected because they invite federal judicial regulation of private insurance transactions, placing insurers in the dilemma of complying with conflicting federal and state regulatory rules. Such federal intervention in state-regulated insurance markets and preemption of state laws—such as the Pennsylvania reform nullified in this case—would be contrary to the congressionally-mandated policy of federal deference to state insurance regulation expressed in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15.

ARGUMENT

I. THE INSURER SUSPENSIONS OF PAYMENT TO MEDICAL CARE PROVIDERS WERE DISCRETIONARY AND PRIVATELY-INITIATED DECISIONS TO USE A PRIVATE REMEDY TO ENFORCE CONTRACTUAL RESTRICTIONS ON INSURANCE COVERAGE

Workers' compensation insurance is a form of liability insurance. Liability insurance indemnifies the insured against liabilities to third parties imposed by state (or federal) law. One of the liabilities imposed on private businesses, in their capacity as employers, is compensation for lost wages and medical treatment to employees who suffer occupationally-related injuries. 77 Pa. Stat. Ann. §§ 531(1), 717.1(a).

With certain limited exceptions, the Commonwealth of Pennsylvania and most other states require employers to financially secure the obligation to pay these benefits either by qualifying to self-insure or by purchasing workers' compensation insurance from a licensed insurer. 77 Pa. Stat. Ann. § 501(a)(1). Property and casualty insurers, however, are not required by the state to provide this type of insurance. Their decisions to enter or exit the workers' compensation insurance market are a matter of private business decision. Similarly, insurers have broad discretion in determining which employers they will underwrite, based on their independently-determined underwriting

standards and evaluation of risk. The relationship between insurer, insured employer, employee and medical care provider is thus a voluntary contractual one, albeit one extensively regulated by the state.[3]

Workers' compensation insurers, like most other types of regulated businesses, are subject to general statutory standards of conduct and agency oversight but, within these broad constraints, have wide discretion in making their business decisions. This case involves one such privately-determined choice.

Workers' compensation laws require the employer to provide medical treatment to workers for occupationally-related injuries but only for treatment that is "reasonable and necessary" for the employee's recovery and return to work. The medical component of workers' compensation thus is not tantamount to health insurance broadly providing coverage for all types of treatment but limits treatment in accordance with a return-to-work objective. Because workers' compensation insurance indemnifies employers only for this limited statutory obligation, the standard workers' compensation insurance policy used in Pennsylvania (as in most other states) reflects the statutory limitation of benefits to treatment that is "reasonable and necessary."

Prior to 1993, Pennsylvania, unlike most other states, significantly limited the insurer's remedies for enforcing the contractual limitation of benefits to "reasonable and necessary" treatment. Even if the insurer had grounds for believing the treatment to have been unnecessary or unreasonable, it was required to pay the provider after receipt of the bill. *See* R. VICTOR J. GARDNER, D. SWEENEY & C. TELLES, WORKERS' COMPENSATION RESEARCH INSTITUTE, COST DRIVERS IN SIX STATES 94 (1992). The

[3] *See* 7B JOHN A. APPLEMAN, INSURANCE LAW AND PRACTICE § 4624 ("[o]bligations assumed by a workers' compensation insurer are contractual in nature").

insurer's only remedy was to obtain an "Independent Medical Evaluation" ("IME") of the treatment by another provider and then, if the IME found the treatment to be unreasonable or unnecessary, to seek review of the treatment by a state administrative law judge. D. BALLANTYNE & C. TELLES, WORKERS' COMPENSATION RESEARCH INSTITUTE, WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY 58-71 (1991). But even if the insurer (or self-insured employer) prevailed, by law it could not recover the payment from the provider. *See Moats v. Workmen's Compensation Appeal Bd.*, 588 A.2d 116, 118 (Pa. Commw. Ct. 1991). The insurer's sole recourse was to obtain reimbursement from a special state "supersedeas" fund that was financed solely by assessments on the insurers and self-insureds themselves. BALLANTYNE & TELLES, *supra*, at xix, 38.

Not surprisingly, this "pay first, review later" system created a strong incentive for provider fraud and overtreatment—the provider was assured of payment notwithstanding the coverage limitations in the insurance policy. VICTOR, GARDNER, SWEENEY & TELLES, *supra*, at 94. In response, as one part of a package of comprehensive reforms, in 1993 the Pennsylvania legislature gave insurers a "self-help" remedy for enforcing the contractual coverage restriction that did not involve the active assistance of state officials. The insurer could elect to seek "utilization review" of questionable treatment by panels comprised of providers from the private sector. *See* 77 Pa. Stat. Ann. § 531(6). So that the utilization review decisions would be meaningful, the insurer was given the discretion—but was not required—to withhold payment of a provider's disputed bill pending the outcome of the review. *See id.* § 531(5); 34 Pa. Code § 127.208(e).

The issue presented in this case is whether this privately-initiated decision by the insurer to use a state-authorized, but private, remedy to enforce its contractual rights should be imputed to the state and thus subject to the Due Process Clause of the Fourteenth Amendment. Relying

heavily upon the regulated status of workers' compensation insurers, the Third Circuit held that insurer decisions to withhold payment of disputed bills pending utilization review was state action under all of the various tests elaborated by this Court. *Sullivan*, 139 F.3d at 170.

This decision should be reversed for one basic reason. Although Pennsylvania extensively regulates workers' compensation insurance, the insurer decisions challenged here —to withhold payment of disputed bills—were within the zone of business judgment left to the insurers by the regulatory scheme. The state thus cannot be deemed to be responsible for the private choice of the insurer and that decision is not subject to due process constraints.

II. NEITHER WORKERS' COMPENSATION INSURERS NOR SELF-INSURED EMPLOYERS PERFORM EXCLUSIVE OR EVEN TRADITIONAL STATE FUNCTIONS

One of the principal grounds upon which the Third Circuit based its finding of state action was the supposed exercise by workers' compensation insurers of powers that are "exclusively within the prerogative of the State." 139 F.3d at 170. In applying this "governmental function" standard, the lower court acknowledged that "insurance companies are private entities." *Id.* at 168. Nevertheless, it held that the insurers are "an arm of the State, fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system." *Id.* This holding was based on a fundamental mischaracterization of workers' compensation laws—these statutes do not impose any payment obligation on the state itself and thus do not delegate to insurers any public function to administer a state obligation.

This Court first attributed the conduct of a private party to the state under a "public function" rationale in *Marsh v. Alabama*, 326 U.S. 501, 506-08 (1946), where a private business operating a "company town" performed

all of the necessary functions of a municipality. Subsequently, in *Jackson v. Metropolitan Edison Co.*, the Court clarified *Marsh*'s "public function" standard to require that a private actor must perform an *exclusive state function* before its conduct may be attributed to the state. 419 U.S. at 352-53.

Similar to the allegations in this case, the plaintiff in *Jackson* asserted that a utility's decision to terminate her service for nonpayment was state action because state utility statutes gave her an entitlement to "reasonably continuous service." *Id.* at 352. The Court rejected this argument because the "supplying of utility service is not traditionally the *exclusive* prerogative of the State." *Id.* at 353 (emphasis added). "[W]hile the Pennsylvania statute imposes an obligation to furnish service on regulated utilities, it imposes no such obligation on the State." *Id.* The Court warned that a broad reading of the "public function" test to include any industry subject to a governmental service mandate or to "public interest" regulation would impose constitutional constraints on all manner of private business:

> Doctors, optometrists, lawyers, Metropolitan [Edison], and [an] upstate New York grocery selling a quart of milk are all in regulated businesses, providing arguably essential goods and services, "affected with a public interest." We do not believe that such a status converts their every action, absent more, into that of the State.

Id. at 354 (footnote omitted). Since *Jackson*, this Court repeatedly has emphasized this exclusive state function requirement.[4]

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[4] *See Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 161 (1978) (a private party's proposed sale of garnished property under a state Uniform Commercial Code provision did not constitute state action because "the settlement of disputes between debtors and creditors

The obligation to pay workers' compensation benefits to injured workers has *never* been a traditional governmental function, let alone an exclusive one. As this Court recognized in *Dillard v. Industrial Comm'n of Va.*, 416 U.S. 783, 798 (1974), the funds used to pay workers' compensation benefits "are private, not public."

Prior to state adoption of workers' compensation laws in the early part of this century, the states had no responsibility for the payment of benefits to an injured employee. A worker's only recourse for injuries on the job was against the employer in tort. *See* L. FRIEDMAN, A HISTORY OF AMERICAN LAW 262-64, 411-14 (1973); *see also* ARTHUR LARSON, THE LAW OF WORKMEN'S COMPENSATION §§ 4.00-4.30 (1986); Richard Epstein, *The Historical Origins and Economic Structure of Workers' Compensation Law*, 16 GA. L. REV. 775 (1982).

The substitution of statutory remedies for common law ones under workers' compensation laws did not transfer to the state the obligation to compensate injured workers.[5] The statutes simply changed the legal standard governing an *employer's* pre-existing liability from one based on negligence to a no-fault one. Like the utility

is not traditionally an exclusive public function"); *Blum*, 457 U.S. at 1011 (nursing homes do not perform a traditional, exclusive state function); *Rendell-Baker v. Kohn*, 457 U.S. 830, 842 (1982) (provision of educational services, while "no doubt . . . is a public function," is not traditionally an *exclusive* public function); *San Francisco Arts & Athletics, Inc. v. United States Olympic Comm.*, 483 U.S. 522, 545 (1987) (regulation of amateur sports "had always been performed by private entities").

[5] Nor did the state become the insurer or guarantor of the private obligation. The Pennsylvania Workers' Compensation Security Fund referred to by the Third Circuit, 139 F.3d at 168 & n.18, protects employees against insurance company insolvency by guaranteeing the obligations of a bankrupt insurer. However, the Fund is financed exclusively through annual assessments on insurers themselves and thus Pennsylvania assumes no financial obligation even as insurer of last resort. 77 Pa. Stat. Ann. §§ 1053, 1055.

law in *Jackson*, the Pennsylvania workers' compensation statute imposes an obligation on private parties only; "it imposes no such obligation on the State." 419 U.S. at 353.

Thus, even accepting the Third Circuit's characterization of workers' compensation benefits as "constitutionally protected entitlement[s]," *Sullivan*, 139 F.3d at 168, that entitlement is not for *state-provided* benefits but rather for *privately-provided* ones. The payment of these benefits, therefore, does not represent the exercise of a government function but merely the satisfaction of a private party's financial obligation imposed by state law.[6]

The private nature of this obligation is not converted into a governmental obligation because of the exclusive remedy provision of the Pennsylvania workers' compensation law, relied upon so heavily by the Third Circuit. 139 F.3d at 168 (citing 77 Pa. Stat. Ann. § 481(a)). Whether the compensation remedy is one exclusively at common law (as formerly) or pursuant to statute (as now), the financial obligation to pay compensation falls upon the employer, not the state. The state merely prescribes the substantive law governing this private obligation, as it does in other types of tort or statutory schemes of compensation. The fact that state substantive law governs the rights and remedies of private employers in

[6] The lower court's analogy to *West v. Atkins*, 487 U.S. 42 (1988), is thus misplaced. In that case, the *state* itself had a constitutional obligation to provide medical care to prison inmates. *Id.* at 54 (citing *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). It delegated that responsibility to a physician who, under contract with the state, assumed responsibility for the performance of the state's constitutional duty. *Id.* at 55. Here, in contrast, Pennsylvania has no governmental obligation to pay benefits; it is "[t]he *employers* [who] are under an affirmative obligation to insure their employees for work-related accidents." *Sullivan*, 139 F.3d at 169 (emphasis added). The employer accordingly is not delegated any responsibility, by contract or by law, to act as an agent or contractor of the state in fulfilling a *state* obligation.

disputes with their employees does not confer a governmental function on those private parties. *See Flagg Bros.*, 436 U.S. at 160-61. The Third Circuit thus was mistaken in equating the "exclusivity" of the statutory remedy with the very different exclusivity requirement of the public function test.

Like employers, workers' compensation insurers do not perform a function that historically has been the exclusive prerogative of the State. Privately-owned property and casualty insurers underwriting coverage indemnifying insureds against liabilities were in existence long before the first workers' compensation laws were enacted. *See Paul v. Virginia*, 75 U.S. (8 Wall.) 168, 183 (1868) (discussing indemnity insurance contracts over 40 years before the first workers' compensation law was adopted in the United States). When those workers' compensation laws imposed the compensation obligation on employers, private insurers voluntarily elected to sell insurance covering those liabilities. This was not a function that the states traditionally had performed.

Indeed, insurers are not even subject to the state-imposed compensation mandate relied upon by the Third Circuit. Neither the Pennsylvania workers' compensation law nor the Commonwealth's insurance code require property and casualty insurers to underwrite workers' compensation coverage for employers. The decision to do so is entirely voluntary on the part of insurers.[7] Their coverage obligations thus arise as a result of private contracts, not a statutory mandate.

Nor does the state delegate to insurers (or self-insured employers) any traditional governmental responsibility for investigating and settling claims. State workers' com-

[7] *Cf.* 7B APPLEMAN, *supra*, § 4597 (insurers have choice of "whether to write the risk at all").

pensation agencies, such as the Pennsylvania Workers' Compensation Bureau, never have had this responsibility. Historically, the claims administration function has been performed by the claims department of the insurer or the human resources or benefits divisions of the employer.[8]

The Third Circuit was equally incorrect in characterizing the right to withhold payment to medical care providers as a "power that traditionally was held in the hands of the State." 139 F.3d at 168. Because the obligation to make such a payment never belonged to the state, the power to withhold payment was not a function ever exercised by the state. Historically, the insurer's right to refuse payment of a claim arose under the terms of the insurance contract itself.[9] That many states, including Pennsylvania, have chosen to regulate or limit this right does not transform it into a traditional or "exclusive prerogative of the state." *See Jackson*, 419 U.S. at 353.

In sum, the Third Circuit's expansionist interpretation of the "public function" standard should be rejected for the same reasons as in *Jackson*. The fact that the government imposes a regulatory mandate on a private party, whether a mandate to provide services or benefits (such as the payment of compensation) or a mandate to purchase (such as a requirement to purchase insurance or self-insure), does not represent the delegation of a gov-

[8] *See* 2 BUSINESS INSURANCE LAW AND GUIDE § 13.08[1] (1998) (when a worker is injured, "he is to give notice of the injury to his employer . . . so as to enable the employer to provide prompt medical diagnosis and treatment and to initiate an investigation of the facts surrounding the injury"). The state's role is limited to that of a neutral adjudicator at a later point in time, if and when a dispute over payment of compensation is brought before a state administrative law judge. *See* 77 Pa. Stat. Ann. § 531(6)(iv); 34 Pa. Code § 127.208(f).

[9] *See* 6B APPLEMAN, *supra*, § 4255 (an insurer is not liable if a claim "is clearly not within the scope of the policy's coverage").

ernmental duty when the state itself has never assumed that obligation.

III. REGULATED INSURERS ARE NOT AN "ARM" OF THE STATE BUT HAVE AN ARM'S LENGTH RELATIONSHIP WITH IT

Alternatively, the Third Circuit found the private insurer defendants to be state actors under the "joint participation" or "symbiotic relationship" standard first expressed in *Burton v. Wilmington Parking Auth.*, 365 U.S. 715 (1961). The appellate court held that the Pennsylvania workers' compensation law "inextricably entangles the insurance companies in a partnership with the Commonwealth such that they become an integral part of the state in administering a statutory scheme." 139 F.3d at 170. In so ruling, the court misconceived the principle underlying the "joint participation" test.

In order for private actors to be "joint participants" with the state, there must be some financial interdependency, state-granted assistance or similar mutually-beneficial relationship. In *Burton*, the Court found joint participation sufficient to constitute state action when a private restaurant owner and a municipal parking authority received mutual financial benefits from their relationship, including a tax exemption for the private party and increased revenue for the state arising out of restaurant profits earned as a result of the alleged racial discrimination. 365 U.S. at 723-24.

This Court repeatedly has rejected the notion that state regulation of private businesses, even extensive and pervasive regulation, creates this interdependency. "[P]rivately owned enterprises providing services that the State would not necessarily provide, even though they are extensively regulated, do not fall within the ambit of *Burton*['s]" joint participation standard. *Blum*, 457 U.S. at

1011.[10] Indeed, in *Blum*, the Court refused to find "joint participation" between a private nursing home and the state, even though the state paid for nursing home services under the Medicaid program and the challenged practices financially benefited the state by reducing Medicaid costs. 457 U.S. at 1005.

In this case, the relationship between the Commonwealth of Pennsylvania and private insurers or self-insured employers manifests none of the characteristics of financial interdependence or mutual benefits that satisfy the "joint participation" standard laid out by the Court. Unlike Social Security, Medicare and Medicaid, the state does not finance workers' compensation benefits through taxpayer funds or otherwise subsidize employers or insurers. The state does not have a proprietary relationship with insurers or employers like the governmental lessor in *Burton*. Nor does Pennsylvania share financial risk with insurers even to the extent of the Medicaid cost reduction found insufficient to support joint participation in *Blum*.

Moreover, contrary to the lower court's characterization of the regulatory scheme, Pennsylvania has not delegated any administrative power to insurers. Insurers investigate claims and suspend payments for disputed claims, not because the state has delegated to them this authority, but because they have financial interests and rights independently arising from their contracts of insurance. The administration of the state's regulatory scheme is performed exclusively by state officials, and insurers are bound by any regulations promulgated by the state. The relationship is an arm's-length one between the regulated insurer or employer and state regulators who are required to be independent of those they regulate.

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[10] *See also Jackson*, 419 U.S. at 350, 358; *Rendell-Baker*, 457 U.S. at 841; *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 176-77 (1972).

IV. PENNSYLVANIA DID NOT COMPEL OR ACTIVELY ENCOURAGE THE INSURER DECISIONS BUT MERELY ACQUIESCED IN THEM

Contrary to this Court's focus in state action cases involving private parties, the Third Circuit's emphasis was on Pennsylvania's general scheme of regulation, irrespective of whether the specific private conduct at issue—the withholding of claims payments—was directly subject to a regulatory mandate or directive. *See Rendell-Baker*, 457 U.S. at 841. The lower court did find, however, what it characterized as state approval of the insurer's decision to suspend payment of provider bills "because an insurer cannot suspend medical payments without first obtaining authorization from the Bureau." 139 F.3d at 168. The court thus concluded that the challenged insurer activities satisfied this Court's "active encouragement" test for finding state action. *Id.* at 170.

In fact, Pennsylvania's involvement is limited to (1) a statute affording insurers the option of withholding payment but without requiring them to obtain case-by-case state approval in order to do so and (2) a regulation requiring an after-the-fact notice filing with the Bureau which is reviewed solely for conformance with procedural filing requirements. This generic statutory authorization of an elective private remedy and passive acquiescence in the insurer's decision to use that remedy falls far short of the state compulsion, coercion, enforcement or "active assistance" necessary to attribute the conduct of regulated parties to the state.

On its face, the Pennsylvania utilization review statute does not *demand* that an insurer request such review nor does it *require* the insurer to withhold payment of bills if it makes such a request. Rather, the statute and its implementing regulations are permissive: "The 30-day period in which payment shall be made to the provider *may* be tolled only if review of the reasonableness or necessity of

the treatment is requested." 34 Pa. Code § 127.208(e) (emphasis added). Thus, an insurer, acting entirely under its own volition, may choose to dispute the reasonableness of treatment and additionally elect to withhold payment pending resolution of the dispute. The lower court in fact acknowledged the permissive nature of the statute. 139 F.3d at 164 ("The Act does not require—but permits—suspension of medical benefits.").

Further, what the Third Circuit characterized as "authorization" by the Bureau amounts to nothing more than a bureaucratic rubberstamp after the insurer files a request for utilization review:

> The Bureau reviews the Initial Request to ensure that it is properly completed—*i.e.*, that all information required by the form is provided. *See* 34 Pa. Code § 127.452. The Bureau's review of the Initial Request does not address the legitimacy or lack thereof of the request for utilization review.

Id. at 163. This notice filing, moreover, is made only *after* the insurer already has made the decision to suspend payment pending utilization review. The state thus undertakes no review whatsoever—even a clerical review—of that decision. Pennsylvania's *de minimis* involvement in the insurer's decision does not even come close to constituting "active state encouragement" under this Court's standard.

The "active encouragement" decisions of this Court focus on the degree of choice permitted a private actor under state law. Thus, a regulated company's "exercise of the choice allowed by state law where the initiative comes from it and not from the State, does not make its actions in doing so 'state action' for purposes of the Fourteenth Amendment." *Jackson*, 419 U.S. at 357 (footnote omitted). In the few cases where this Court has found state action under the "active encouragement" standard, the State has had a substantial role in controlling the pri-

vate decision by coercing, compelling or enforcing it. *See Peterson v. Greenville*, 373 U.S. 244, 247-48 (1963) (city ordinance required private restaurant owner to segregate on basis of race); *Shelley v. Kraemer*, 334 U.S. 1 (1948) (racially restrictive covenant enforced by state courts); *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 627-28 (1991) (state courts enforced race-based peremptory challenges). But "[t]his Court . . . has never held that a State's *mere acquiescence* in a private action converts that action into that of the State." *Flagg Bros.*, 436 U.S. at 164 (emphasis added).

The limited scope of the "active encouragement" test was expressly recognized in *Blum*, where the Court held that "a State normally can be held responsible for a private decision only when it has *exercised coercive power* or has provided such *significant encouragement*, either overt or covert, that the choice must in law be deemed to be that of the State." 457 U.S. at 1004 (emphasis added). There, plaintiffs challenged under the Due Process Clause a private nursing home's decision to transfer Medicaid patients. Applicable New York regulations authorized nursing homes to make patient transfer decisions and spelled out the general criteria for making those decisions. *Id.* at 1006. The regulations required nursing homes to use utilization review in making transfer decisions and they were subject to sanctions for failing to do so. *Id.* at 994-95. Nevertheless, those regulations were insufficient to attribute the nursing home decisions to the state because the decisions "ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State." *Id.* at 1008.

In two respects, the Pennsylvania statute at issue here affords insurers greater discretion than the New York regulations gave nursing homes and thus surely cannot be considered to have directed or controlled insurer decisions.

First, the Pennsylvania utilization review provision is permissive, unlike the mandatory New York provision. Second, unlike the New York regulations, the Pennsylvania statute sets forth no substantive criteria whatsoever governing the insurer's right to suspend payment of provider bills.

At most, the Pennsylvania statute only authorizes insurers to use a "self-help" measure to protect their financial interests without the need to institute any state proceeding or obtain the active assistance of any state official. There is no state action because the state "has merely announced the circumstances under which it[] . . . will not interfere with a private" remedy. *See Flagg Bros.*, 346 U.S. at 166. Put differently, the insurer's use of a "self-executing" statute which tolls the time for payment, like a statute of limitations, does not implicate the state in a private action. *See id.* at 166; *see also Texaco, Inc. v. Short*, 454 U.S. 516 (1982).[11]

Nor does the Bureau's filing requirement convert the insurer's discretionary action into state action. Indeed, in *Blum*, the Court rejected the very same argument embraced by the Third Circuit here—that a notice filing with the state transforms private conduct into state action. The State of New York required a nursing home physician to complete a "long term care placement form" devised by the state to assess whether each patient's care

[11] The Third Circuit mistakenly relied upon *Tulsa Prof'l Collection Servs., Inc. v. Pope*, 485 U.S. 478 (1988), in finding that the Pennsylvania statute was not self-executing. In *Pope*, the challenged notice provision became "operative only after probate proceedings have been commenced in state court," and the court has appointed an executor. *Id.* at 487. The probate court there was "intimately involved throughout." *Id.* Here, by contrast, there is no state court or administrative proceeding commenced at the time when the insurer withholds payment of the provider bill. The first state proceedings do not occur until far down the road, after the completion of utilization review and an election by an aggrieved party to appeal that decision to an administrative law judge.

remained "medically necessary." *Id.* at 1006. The Court reasoned that the filing of the form did not convert the private decision of the physician into state action: "[T]he physicians, and not the forms, make the decision about whether the patient's care is medically necessary . . . . *We cannot say that the State, by requiring completion of a form, is responsible for the physician's decision.*" *Id.* at 1006-07 (emphasis added).

Even if Pennsylvania had required the insurer to secure advance Bureau approval of a decision to suspend payment, the insurer decision still could not be attributed to the state. In *Jackson,* electric utilities could terminate service to customers only if they first filed a tariff with state regulators proposing criteria and procedures for termination. The applicable regulatory statute required regulators to substantively review the filing and it went into effect if the regulators found no grounds to disapprove it. The Court refused to attribute the utility's service termination decision to the regulators' approval of the filing because the decision was initiated by the utility and was only acquiesced in, not encouraged, by the regulator:

> The nature of governmental regulation of private utilities is such that a utility may frequently be required by the state regulatory scheme to obtain approval for practices a business regulated in less detail would be free to institute without any approval from a regulatory body. Approval by a state utility commission of such a request from a regulated utility, where the commission has not put its own weight on the side of the proposed practice by ordering it, does not transmute a practice initiated by the utility and approved by the commission into "state action." . . . Respondent's exercise of the choice allowed by state law where the initiative comes from it and not from the State, does not make its action in doing so "state action" for purposes of the Fourteenth Amendment.

419 U.S. at 357. Similarly here, the insurer's determination to suspend payment of disputed bills was the product of its own initiative, not any state compulsion or state policy actively encouraging that decision.[12]

V. THE THIRD CIRCUIT'S STATE ACTION HOLDING WILL INVITE PREEMPTION OF STATE REGULATION AND FEDERAL JUDICIAL REGULATION OF PRIVATE BUSINESSES

At bottom, the Third Circuit's conclusion that the insurers' nonpayment decisions were state action is based entirely on the mere existence of a general scheme for regulating workers' compensation insurance but one which did not compel, actively encourage or enforce the specific insurer decisions in question. This expansionist notion of state action should be rejected, as it has been in prior decisions of this Court, because it would result in wholesale transformation of many private but regulated businesses into state actors subject to direct federal regulation. The lower court's approach, moreover, is a recipe for

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[12] Should the Court overrule the decision below for these reasons, it should additionally overrule the decision of the three-judge panel in *Baksalary v. Smith,* 579 F. Supp. 218 (E.D. Pa. 1984), which was relied upon by the Third Circuit in *Sullivan* and which was based on the same rationale. As in this case, the Pennsylvania statutory provision at issue in *Baksalary* authorized workers' compensation insurers to suspend payment of disability (rather than medical treatment) benefits pending final resolution of a dispute over the employee's eligibility to continue receiving them. As here, the insurer was required to "file a petition on a form provided by the [Bureau of Workers' Compensation]", as well as a physician affidavit attesting to the worker's recovery. 579 F. Supp. at 231. As here, the Bureau's review of the petition was purely procedural: "Although the Bureau does not review the petition's merits, it does review the petition for formal compliance with the Workmen's Compensation Act." *Id.* Because *Baksalary* found "active state encouragement" resting on the same permissive type of statute and simple notice filing relied upon in *Sullivan,* it is flawed in the same respects as the decision under review here.

massive preemption of state regulation under the guise of constitutional doctrine.

The Third Circuit ultimately based its finding of state action on three characteristics of Pennsylvania's "comprehensive statutory scheme" for regulating workers' compensation insurance: (1) the "entitlement" created by the compensation mandate imposed on employers; (2) the "essential" nature of workers' compensation insurance because of the requirement that employers fund benefits by insurance or self-insurance; and (3) the "exclusivity" of the remedy afforded employees under the workers' compensation law. None of these attributes are unique to regulation of workers' compensation insurance but are common to many state insurance regulatory schemes.

Many states impose coverage obligations on private parties that can be characterized as a "guarantee" or "entitlement" by the state in the same way that the Third Circuit characterized workers' compensation benefits—not in the sense that they are financial obligations of the state, but only in the sense that state law imposes the obligation or creates the right. For example, many states mandate the types of health insurance benefits that employers must afford to their employees.[13]

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[13] *See, e.g.*, Mass. Stat. ch. 175, § 47B; Ill. Stat. ch. 215 § 5/367(7); Ariz. Rev. Stat. § 20-1402(4); Conn. Stat. § 38a-514. *See also Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-30 (1985) ("General health insurance typically is sold as group insurance to an employer or other group. Group insurance . . . is subject to extensive state regulation, including regulation of . . . the content of the contracts. . . . Different states mandate a great variety of different kinds of insurance coverage. For example, many require alcoholism coverage, . . . while others require certain birth-defect coverage, . . . outpatient kidney-dialysis coverage, . . . or reconstructive surgery for insured mastectomies.") (citations and footnote omitted). *See generally* EMPLOYEE BENEFITS RESEARCH INSTITUTE, DATABOOK ON EMPLOYEE BENEFITS 269-70 (4th ed. 1997) (listing the "975 different health care mandates in force in the 50 states and the District of Columbia").

Many states also impose insurance purchasing or self-insurance requirements similar to workers' compensation laws. Automobile drivers in all fifty states are required to purchase liability coverage to protect third parties or otherwise to demonstrate financial responsibility before operating a motor vehicle.[14] Some states require companies engaged in the business of remediating pollution from underground storage tanks to provide evidence of financial responsibility, which may be in the form of insurance or self-insurance.[15]

Finally, many state insurance regulatory schemes displace common law remedies and make the statutory remedy exclusive. Many states, for instance, have enacted no-fault automobile insurance laws that displace traditional tort remedies.[16]

These various state insurance laws create third-party "entitlements" or make insurance "essential" or make statutory remedies "exclusive" no less than Pennsylvania's workers' compensation law. Yet, like workers' compensation statutes, these insurance regulatory schemes reserve to insurers a large zone of freedom where decisions are a matter of business judgment subject only to requirements that state regulators receive notice of those decisions (*e.g.*, filings of proposed rates and policy forms) and retain the

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[14] *See, e.g.*, Ariz. Rev. Stat. §§ 4009, 28-4135; Cal. Veh. Code §§ 16020-16021; Ill. Comp. Stat. § 5/7-601; Mass. Ann. Laws ch. 90, §§ 34A-34B; N.H. Rev. Stat. Ann. § 264:3; N.Y. Veh. & Traf. Law § 312.

[15] *See, e.g.*, 35 Pa. Stat. Ann. § 6021.701; N.J. Stat. Ann. §§ 58:10A-24.3, 58:10A-24.4(b).

[16] *See, e.g.*, Col. Rev. Stat. §§ 10-4-701 *et seq.*; Fla. Stat. Ann. §§ 627.730-627.7405; Haw. Rev. Stat. §§ 431:10C-101 *et seq.*; Ky. Rev. Stat. Ann. §§ 304.39-010 *et seq.*; Mass Ann. Laws ch. 90, § 34M; Mich. Stat. Ann. §§ 24.13101 *et seq.*; Minn. Stat. §§ 65B.41 *et seq.*; N.J. Stat. Ann. § 39:6A-4; N.Y. Ins. Laws §§ 5101 *et seq.*; N.D. Cent. Code §§ 26.1-41-01 *et seq.*; 75 Pa. Cons. Stat. §§ 1701 *et seq.*; Utah Code Ann. §§ 31A-22-301 *et seq.*

power to intervene. Further, none of these insurance regulatory statutes delegates to the insurer the power to exercise any regulatory or administrative function on behalf of the state. Under these permissive schemes of regulation, the role of the insurer is not as an agent, "arm" or "appendage" of the state as the Third Circuit viewed it. The insurer does not *act* as regulator but is *subject* to regulation.

Under the Third Circuit's expansive state action tests, however, the discretionary business judgments of private insurers would be subject to the full panoply of constitutional constraints across the entire spectrum of their business activities. The mere fact that the state imposes a liability, or that a policyholder is required to buy insurance, or that the insured's statutory remedies are exclusive, would make the regulated insurer an "arm" of the state in administering an "exclusive" system of "public benefits." Private insurance contracts would become a state entitlement requiring the insurer to treat claimants as if they were beneficiaries of public funds. A wide variety of insurer functions would thereby become subject to constitutional regulation including, for example, underwriting decisions (because they affect the ultimate availability of the "entitlement") and coverage or claims decisions (because they immediately affect the availability of the "entitlement").

Insurers would be placed in the dilemma of either paying claims that they believe exceed their contractual obligations, in order to avoid liability for damages under 42 U.S.C. § 1983, or providing formal hearing rights of the type required in judicial proceedings, in order to contest the claim. The entire process by which claims are investigated, negotiated and settled—usually well short of administrative procedings or litigation—would become unnecessarily cumbersome, adversarial and costly. Underwriting and claims activities would become subject to due process constraints irrespective of whether a state law eliminated insurer discretion or whether the insurer

had the active assistance of any state official in implementing or enforcing its decision. In addition, insurers would become subject to equal protection constraints directly colliding with one of their primary business functions—discriminating between risks on the basis of actuarial differences.

The Third Circuit's expansionist state action tests not only would usurp insurer contractual rights but threaten state regulatory power in the area of insurance claims disputes. State claims regulation would become subject to constitutional preemption notwithstanding the state's decision to encourage the private resolution of claims disputes. Even if the insurer claims practices in question are discretionary and privately-initiated ones, the state would become responsible for the private action and its regulatory scheme subject to collateral attack.

The likely consequences of the Third Circuit's approach —increased preemption of state law and federal judicial regulation of private insurance transactions—is fundamentally in conflict with the purpose of 42 U.S.C. § 1983 and the Fourteenth Amendment. The objective of both is to protect private persons from the arbitrary actions of state officials and agencies, not to expand federal authority to regulate those persons directly through a "court-made scheme of federal constitutional regulation." William M. Burke & David J. Reber, *State Action, Constitutional Power and Creditors' Rights: An Essay on the Fourteenth Amendment*, 46 S. CAL. L. REV. 103, 193 (1973); *see also* Henry C. Strickland, *The State Action Doctrine in the Rehnquist Court*, 18 HASTINGS CONST. L. Q. 587, 595 (1991).

The state action requirement implements this limitation by preventing federal courts from regulating the conduct of private entities that the Constitution reserves to the states: "By limiting the [Fourteenth] Amendment's application to state governmental actors, . . . the state action requirement prevents federal courts from using the Amend-

ment to regulate private activity that the Constitution reserved for state—not federal—authority." Strickland, *supra*, at 595-96. The state action requirement "also prevents the federal courts from using the Fourteenth Amendment to usurp authority that the Constitution granted to the executive and legislative branches. . . . By limiting the application of the Fourteenth Amendment to governments, the state action requirement prevents federal courts from directly regulating private activity that the Constitution deemed best governed by the representative branches." *Id.* at 596 (footnote omitted).

The Third Circuit's treatment of regulated insurers as "partners" of the state fundamentally subverts these principles by transforming the Fourteenth Amendment and Section 1983 from shields against arbitrary government actions into vehicles for increased federal judicial regulation of private insurance transactions. This new layer of federal regulation of the insurer-policyholder relationship would be imposed notwithstanding Congress' decision, in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, to defer to state regulation of the "business of insurance"—the heart of which has been defined as the relationship between the insurer and insured. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 215-17 (1979); *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 128-29 (1982). Indeed, this Court specifically has held that the performance of the insurer's obligations under the contract of insurance—the very matter at issue here—is exclusively subject to state regulation. *United States Dep't of the Treasury v. Fabe*, 508 U.S. 491 (1993). The Third Circuit's state action finding ultimately should be rejected because it is an open invitation to the lower federal courts to regulate claims disputes between insurers and insureds based on policy judgments contrary to those made by the state regulators to whom deference is constitutionally and statutorily due.

This case provides a perfect illustration of how a decision nominally applying the Due Process Clause to the

conduct of regulated insurers is really secondguessing of state regulatory policy. In effect, the Third Circuit made a policy judgment that a patient's or provider's right to prompt payment of medical bills trumped the public interest in combating provider fraud and containing the cost of medical care. This judgment, however, is squarely at odds with the judgment of the Pennsylvania legislature.

Prior to 1993, workers' compensation markets in Pennsylvania and many other states suffered turmoil as medical care costs associated with workers' compensation accelerated steeply, at rates far greater than health care costs generally.[17] A major cause of these exploding medical expenses were the incentives under the workers' compensation law for providers to overbill and overtreat. There were few limits placed under the Pennsylvania system on the selection of providers and on the treatment given by those providers. Of particular relevance here, while an employer or insurer could challenge a provider's treatment as unnecessary or unreasonable, that provider would continue to receive payment pending the resolution of the challenge and was not required to disgorge the payment even if the treatment ultimately was determined to be unnecesary or unreasonable.[18]

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[17] *See* BALLANTYNE & TELLES, *supra*, at 30 (discussing "spiraling costs of medical treatment for work-related injuries" as a "significant problem[] in the Pennsylvania system"). *See also* S. ECCLESTON & C. YEAGER, WORKERS' COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION, A NATIONAL INVENTORY, 1997-1998, at 4 (1997) (from 1985 to 1992, aggregate national medical expenditures for workers' compensation rose 157 percent, compared to a 94 percent rise in national health care costs overall); Emily Spieler, *Perpetuating Risk?*, 31 HOUS. L. REV. 119, 135 (1994) (in a 1991 "industry survey, seventy percent of employers reported that workers' compensation costs were threatening their financial results") (footnote omitted).

[18] *See* VICTOR, GARDNER, SWEENEY & TELLES, *supra*, at 94. *See also* BALLANTYNE & TELLES, *supra*, at xxi (as of 1991, "Pennsylvania employ[ed] few of the cost containment strategies common to other states . . . .").

As noted, in 1993, the Pennsylvania legislature acted to eliminate this incentive for overtreatment by permitting insurers and self-insured employers to forebear payment of health care provider bills pending utilization review of the reasonableness or necessity of the treatment given. *See* 77 Pa. Stat. Ann. § 531(5); 34 Pa. Code § 127.208. The 1993 reforms in general and the utilization review system in particular proved effective. "The most notable system improvement was a sharp drop in medical benefit costs from 1993 to 1995," attributable in large part to the "medical cost controls instituted by the 1993 amendments." D. BALLANTYNE, WORKERS' COMPENSATION RESEARCH INSTITUTE, REVISITING WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY at xi (1997).

In over two-thirds of the cases submitted for utilization review, all or some of the medical treatment was found to be unnecessary or unreasonable. Letter from Timothy Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Pennsylvania Bureau of Workers' Compensation (July 1, 1998) (reproduced in the Appendix to the Brief of *Amici Curiae* American Insurance Association, *et al.*, in Support of the Petition). By detecting this overtreatment, the utilization review system produced approximately $32 million in direct annual savings. Letter from Timothy Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Pennsylvania Bureau of Workers' Compensation (October 29, 1998) (reproduced in the Appendix to this brief).

The Third Circuit's decision, however, threatens to render utilization review meaningless as a mechanism to prevent unreasonable and unnecessary treatment. By striking down that part of the statute that allows insurers to delay payment pending utilization review, the court has recreated a system under which insurers must "pay first, review later." Thus, despite the nominal existence of a "review" system, providers will again have an incentive to bill for improper treatment because they know that they will receive payment promptly, irrespective of whether the treatment provided was reasonable and necessary, and that they will not be required to disgorge payment irrespective of the outcome of the "review." The Third Circuit's ruling resurrects a system fostering provider fraud and abuse and frustrating the purpose of the 1993 cost containment reforms. Indeed, the lower court's decision already has had a chilling effect on utilization review, which has declined 60 percent. *See* Appendix.

In addition, the decision below would require insurers and private utilization review panels to adopt quasi-adjudicative procedures for handling claims disputes that could impose significant new costs. More importantly, and ironically, the lower court's decision creates a huge loophole in Pennsylvania's exclusive remedy provision so heavily emphasized by the Third Circuit. Unlike governmental entities, if private insurers are treated as state actors, they may not have sovereign immunity from damages claims asserted under 42 U.S.C. § 1983. The award of such damages would obviously be inconsistent with the exclusive remedy limitation in the Pennsylvania law by allowing an employee to recover a greater amount than permitted under the policy and under the statutory limitations on benefits.

As a result, the decision below is likely to lead to a significant increase in insurance claims costs as insurers pay for unreasonable or unnecessary treatment or for Section 1983 damages going beyond their policy obligations. Although insurers and self-insured employers may recover from a "supersedeas" fund for excessive payments made to medical care providers, 34 Pa. Code § 127.208 (g), that fund is financed by assessments on them. Therefore, insurers and self-insured employers essentially bear the entire cost of the unreasonable and unnecessary treatments. As that cost increases, insurers may either increase their rates or decide not to cover the risk, decreasing insurance availability and potentially recreating the pre-

1993 crisis in the Pennsylvania workers' compensation market.[19] Such constrictions on insurance availability and affordability make insurance less efficient as a means of spreading and minimizing the costs of the workers' compensation, adversely affecting benefits, employment and wages.

In sum, although intended to advance the procedural rights of injured workers, the Third Circuit's ruling may ultimately harm the basic economic intersts of those very workers. This is precisely why, under our constitutional framework, judgments about economic and social regulatory policy are reserved to the states and the representative branches of the federal government.

CONCLUSION

For the reasons stated herein, the judgment of the United States Court of Appeals for the Third Circuit should be reversed.

Respectfully submitted,

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[19] *See* Floor Statement of Rep. Fargo, Pa. House Journal at 547 (Mar. 30, 1993) (noting need for reform and cost containment measures, because "insurance companies, an awful lot of them in Pennsylvania, are refusing to write workers' compensation"); *see also SMC/Pennsylvania Small Business: Small Business Hurt Most by Delay in Reform of Workers' Compensation Crisis*, PR Newswire (June 1, 1992) (small business owner lamented: "We've had an average increase in our insurance rates of 35 percent a year. . . . My insurance agent tells me that it's getting harder and harder to find any companies that will sell me workers' compensation insurance").

APPENDIX

APPENDIX [1]

[PCRB Logo]

PENNSYLVANIA COMPENSATION
RATING BUREAU
The Widener Building • 6th Floor
One South Penn Square
Philadelphia, PA 19107-3577
(215) 568-2371 • FAX (215) 564-4328

October 29, 1998

VIA FACSIMILE & FIRST CLASS MAIL

Mr. Richard Himler
Director
Pennsylvania Bureau of Workers' Compensation
Department of Labor & Industry
Commonwealth of Pennsylvania
1171 South Cameron Street, Room 103
Harrisburg, PA 17104-2501

RE: Utilization Review Experience Under Pennsylvania's Workers Compensation Act

Dear Mr. Himler:

This letter revises and supersedes my correspondence of October 28, 1998 and supplements my correspondence of July 1, 1998 concerning analysis which the Pennsylvania Compensation Rating Bureau (PCRB) continues to perform with respect to the utilization review processes in Pennsylvania in the context of the Sullivan decison. In particular, this letter will update you concerning our work to date in attempting to quantify the historical dollar impact of utilization review on workers compensation costs in Pennsylvania.

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[1] A copy of this letter was lodged with the Office of the Clerk of the Supreme Court on the date of filing of this brief.

The PCRB's interest in this matter derives from our responsibilities as the licensed rating organization for workers compensation insurance other than coal mine exposures in Pennsylvania. We are sharing the results of our work with you, recognizing the key role which the Department of Labor and Industry, Bureau of Workers' Compensation (BWC) plays in the effective and equitable administration of many provisions of the Pennsylvania Workers Compensation Act, and as a nominal means of reciprocating for the many courtesies which your office has previously extended to us in sharing information and insights pertaining to the Pennsylvania workers compensation system.

Based on the data previously provided by your agency, the PCRB has been able to identify the predominant types of medical providers historically involved in utilization review requests in Pennsylvania. Of some 25,265 such requests with identified provider types, approximately 37 percent were for chiropractors, 17 percent for family doctors or general practitioners, nine percent for physical therapists and six percent for othopedic doctors.

The PCRB has attempted to complement the comprehensive information related to the incidence and disposition of utilization review requests previously provided to us by your office with details concerning the dollar value of medical services addressed by utilization review requests. As identification of such dollar values is an inherently labor intensive process requiring access to individual claim file documentation, the PCRB has sought this additional data by asking selected carrier members to review their own claims for which utilization review requests were previously made on a sampling basis. The PCRB has discussed the information provided in response to these requests with each of the carriers which have given us information in order to enhance our understanding of the form and content thereof. We have relied on the accuracy of the individual claim detail submitted to us without independent verification.

As of this writing, the PCRB has received and reviewed claim detail information from four separate carriers. In total some 363 claims have been thus reviewed and reported to the PCRB. This currently available data is limited, and the PCRB continues to attempt to obtain additional information from a broader complement of insurers. However, our analysis of this preliminary information has produced substantive indications that the utilization review process in Pennsylvania prior to the Sullivan decision had resulted in significant savings of medical costs through the identification of unreasonable and/or unnecessary medical treatment.

The following is a synopsis of key results of our analysis and their implications for the probable effects of utilization review pre-Sullivan on the prevailing and continuing cost of Pennsylvania workers compensation claims.

- Based on the sample of 363 claims reviewed to date, the PCRB estimates the net direct savings attributable to utilization review before the Sullivan decisions at approximately $32 million per year. These savings are "net" in the sense that they recognize the costs of reimbursing the Utilization Review Organizations (UROs) for their services related to the adjudication of utilization review requests and have also been adjusted for incidental litigation expenses such as costs for expert witnesses and attorneys' fees. These savings are "direct" in that they are limited strictly to the population of claims for which utilization review requests were actually filed on an annual basis since the inception of the utilization review process in late 1993.
- A substantial majority of the above referenced estimated net direct savings are attributable to the cessation or modification of proposed medical services *after* the rendering of utilization review decisions. In other words, the *prospective* changes in authorized medical procedures are responsible for significantly more of the

observed direct effects of utilization review determinations on medical costs rather than is the denial of payment for *previously rendered or recommended* services.

- The *indirect* effects of utilization review decisions on medical costs are potentially much greater than the *direct* effects of these decisions. (By "indirect" effects we are referring to influences on medical treatments recommended or performed on claims for which utilization review requests have *not* been filed but which present similar circumstances to other claims in which utilization review requests *have* been filed and determinations have been rendered that certain types of treatment are not reasonable or necessary.) This is the case because many more claims may be affected by such precedents than are required to establish them. A given provider may change their approach(es) to treatment of certain conditions based on a relatively small number of personal and/or anecdotal experiences in the utilization review process, but those changes once made will often apply to a much greater number of similar future cases.
- To the extent that there is *any* indirect effect of utilization review decisions on medical costs for workers compensation claims, estimates of the effects of this process on costs which are limited to evaluations of cases for which utilization review requests were actually filed will be somewhat understated. Because the PCRB believes, based on all available information, that the indirect effects of utilization review findings in Pennsylvania have likely been quite significant, we are also of the opinion that the actual effect of this process pre-Sullivan was substantially greater than the estimate of $32 million per year noted above.
- Finally, the PCRB understands that, since the issuance of the Sullivan decision, the numbers of utilization review petitions being presented to the Department of

Labor & Industry, Bureau of Workers Compensation (BWC) and subsequently assigned to UROs for action has declined markedly. For example, your office has informed us that for the six months ending December 31, 1997 a total of 3,569 utilization review requests were assigned by the BWC. The Sullivan decision was rendered in March 1998. For the six months ending September 30, 1998 a total of only 1,478 utilization review requests were assigned by the BWC, a decline of almost 60 percent from pre-Sullivan levels. This suggests that in the near term the Sullivan decision materially reduced the use of utilization review processes as a means of monitoring and controlling medical costs associated with unreasonable and/or unnecessary treatment in Pennsylvania.

The PCRB will continue to assimilate additional claim detail data into our estimates if and when that information is received and will keep your office apprised of the results of that continuing effort as they become available. Should you have any questions or comments in regard to this ongoing evaluation, I am available at your request to respond to them.

Sincerely,

/s/ Timothy L. Wisecarver
TIMOTHY L. WISECARVER
President

TLW/kg